Date of Service: MM / DD / YY	Provider Staff ID:	Location of Service: 1-Office, 2=Field, 3=Phone, 4=Home, 5=School, 6=Satellite, 7=Crisis Field, 8=Jail, 9=Inpatient.
Focus of today's treatment DSM-IV-TR Diagnosis Code(s): _____ ICD-9-CM Billing Code(s): _____		

A. Vital Signs: (if needed) Blood Pressure_____ Pulse_____ Temp_____ Weight_____ Girth_____ Height_____ BMI _____

Comments: _____

Has client taken medication as prescribed? ☐Yes ☐No_____

Any changes of other medications since last visit? (include over the counter) ☐ NO_____

Substance use? ☐Yes ☐No If yes, specify substance:_____

_____

Signature /Title Printed Name Date Face to Face Time/Total Time CPT/HCPCS Code

B. Algorithm Rating Scales

Patient Global Self Report (0 - 10) 0=no symptoms, 5=moderate, 10=extreme

Symptom Severity: _____ Side Effects: _____

Participation in Road Map to Recovery groups ☐Yes ☐No Number of Sessions Attended: _____

Clinical Rating Scale: QIDS-SR_____QIDS-C _____

Positive Symptoms (PSRS) _____ Negative Symptoms (BNSA)_____ BDSS _____

_____

Signature /Title Printed Name Date Face to Face Time/Total Time CPT/HCPCS Code

CURRENT ALGO: _____SCHIZ _____MDDNP _____MDDP _____BPD

STAGE: _____; WEEKS IN THIS STAGE: _____;

C. CLINICIAN INFORMATION

Use for all clinicians' rating below: (0-10; 0=No Symptoms; 5=Medium and 10=Extreme)

Core Symptoms: _____Manic _____Depression _____Psychosis Positive Symptoms _____Negative Symptoms

Other Symptoms: _____Irritability _____Mood Lability _____Agitated _____Anxiety _____Level of Interest

_____Appetite _____Energy Level _____Insomnia _____Impulse Control _____Interpersonal Relationships

_____Sexual Functioning Side Effects_____

CURRENT POTENTIAL FOR HARM: Homicidal? ☐Yes ☐No Suicidal? ☐Yes ☐No

Comments:_____

_____

SYMPTOMATIC RESPONSE TO MEDICATION: ☐Full Remission ☐Partial ☐No Change ☐Worsening

If medication type or dose is being changed at this visit, indicate reasons for change.

** ☐Critical Decision Points Indicates Change ☐Diagnosis Change ☐Insufficient Improvements ☐Client Preference

☐Side Effects Intolerable ☐Symptoms Worsening ☐Other (specify)_____

Comments:

_____

_____

_____

_____

D. MENTAL STATUS EXAM:

Level of Consciousness:	☐Alert	☐Lethargic	☐Stuporous			
Orientation:	☐Person	☐Place	Time ☐Day ☐Month ☐Year	☐Current Situation		☐ All Normal
Appearance:	☐Clean	☐Disheveled	☐ Malodorous	☐Well-Nourished	☐Malnourished	☐Obesity	☐ Reddened Eyes
Speech:	☐Normal	☐Slurred	☐Loud	☐Pressured	☐Slow	☐Mute
Thought Process:	☐Coherent	☐Tangential	☐Circumstantial	☐Incoherent	☐Loose Association	
Thought Content	☐Auditory Hallucinations	☐Visual Hallucinations	☐Delusions	☐Ideas of Reference	☐Paranoia	
Behavior:	☐Cooperative	☐Evasive	☐Uncooperative	☐Threatening	☐Agitated	☐Combative
Affect:	☐Appropriate	☐Blunted	☐Flat	☐Restricted	☐Labile	☐Other
Intellect:	☐Normal	☐Below Normal	☐Paucity of Knowledge	☐Vocabulary Poor	☐Poor Abstraction	☐ Uncooperative
Mood:	☐Euthymic	☐Elevated	☐Euphoric	☐Depressed	☐Anxious	☐Irritable
Memory:	☐Normal	☐ Poor Recent	☐ Poor Remote	☐ Inability to Concentrate	☐ Confabulation	☐Amnesia
Insight	☐Normal	☐Adequate	☐Marginal	☐Poor		
Judgment:	☐ Normal	☐Poor	☐Unrealistic	☐Unmotivated	☐Uncertain	
Motor:	☐ Normal	☐Decreased	☐Agitated	☐Tremors	☐Tics	☐Repetitive Motions	☐Psycho-Motor Retardation
Global AIMS:	0	1	2	3	4	

Note: A narrative mental status exam may be done on a progress note, in lieu of above.

DSM IV-TR DIAGNOSIS: _____. ____; _____. ____; _____. ____; _____. ____; GAF: _____

E. Psychotherapeutic interventions: Return visit, discharge planning.

F. Plan/Order/SNP: Psychotherapeutic Interventions: Return visit, discharge planning. Medication Levels. Lab Work.

Signature /Title | Printed Name | Date | Face to Face Time/Total Time | CPT/HCPCS Code

Comments:

Signature /Title | Printed Name | Date | Face to Face Time/Total Time | CPT/HCPCS Code

County of San Diego
Health and Human Services Agency
Mental Health Services

MEDICATION/PROGRESS NOTE

Client

Name:

MR/Client ID #:

Program

Program: **Phone #**

Address: